For information
on 17 June 2013

LEGISLATIVE COUNCIL PANEL ON HEALTH SERVICES
Waiting Time Management for Specialist Outpatient Clinics in Hospital Authority

PURPOSE

This paper briefs Members on the waiting time management of Specialist Outpatient Clinics (SOPC) in the Hospital Authority (HA).

OVERVIEW

2. HA has all along been providing to the public a wide range of public healthcare services at a highly subsidized rate. Amongst these, SOPC service has been facing a huge demand from the public.

3. In 2012-13, the 47 SOPC of HA provided an attendance of 6.9 million, of which 682 000 (9.9%) are first attendances. During the same period, HA registered a total of 811 000 new case bookings at SOPC, a steady increase from 766 000 in 2010-11 and 790 000 in 2011-12. In addition, the volume of follow up attendances had also increased, amounting up to 6 203 000 in 2012-13 when compared with 5 962 000 in 2010-11 and 6 074 000 in 2011-12. Such a rising demand has led to longer waiting time for non-urgent clinical services. The overall HA waiting time for new booking of routine cases in SOPC of major specialties from 2010-11 to 2012-13 is at **Annex 1**.

4. There are a number of factors leading to the increase in waiting time at SOPC. First, our ageing population is associated with a higher prevalence of chronic diseases, which in turn gives rise to an increased demand for healthcare services.

5. Second, in recent years, the public healthcare sector has been experiencing severe manpower shortage. In the past three years, while the attrition rate of doctors in HA has remained stable at 5.2%, 4.8%, and 5% respectively, the number of medical graduates has reduced from 310 a year in

2007, to 280 in 2010, and further down to 250 in 2011. The unmatched replenishment has made HA difficult to cope with the escalating demand, and has considerably affected the waiting time performances for our SOPC services.

6. Furthermore, expansion works with a view to increasing the number of consultation rooms in SOPC are constrained by physical limitation in some hospitals. All these factors have led to the lengthening in waiting time for SOPC services in some clusters and specialties.

7. Details of the SOPC waiting time of new cases of major specialties by the triage categories of the seven hospital clusters in 2012-13 are provided at **Annex 2**. For follow-up appointments, the interval between visits will be determined by the clinical condition of the patients concerned, and is not regarded as waiting time.

STRATEGIES IN WAITING TIME MANAGEMENT

8. In recent years, HA has been implementing a series of measures in managing SOPC waiting time. Details of the measures are provided in the following paragraphs.

(a) Triage and Prioritization

9. Since 2004, HA has implemented the triage system for all new SOPC referrals to ensure that urgent conditions requiring early intervention are treated with priority. Under the current triage system, referrals of new patients are usually first screened by a nurse and then by a specialist doctor of the relevant specialty for classification into priority 1 (urgent), priority 2 (semi-urgent) and routine categories. HA's targets are to maintain the median waiting time for cases in priority 1 and 2 categories within two weeks and eight weeks respectively. HA insofar has been able to keep the median waiting time of priority 1 and priority 2 cases within this pledge.

(b) Enhancing Public Primary Care Service

10. HA is committed to enhancing public primary care services. Patients with stable and less complex conditions can be managed at the Family Medicine and general outpatient clinics, thereby reducing the service demand at

SOPC level. The enhancement measures implemented in the past few years include:

(a) Setting up Family Medicine specialist clinics as gatekeeper for SOPC and for follow up on patients triaged as routine cases;

(b) Updating clinical protocols for referring medically stable patients to receive follow-up primary health care services;

(c) Empowering the access of drug formulary and investigations such as computed tomography and endoscopy to Family Medicine; and

(d) Engaging private counterparts to provide primary care services.

(c) Enhancing Manpower

11. In recent years, HA has enhanced the manpower at SOPC through the employment of part time doctors. As of Mar 2013, the number of part time doctors working in HA was about 290, representing some 110 full time equivalent doctors. Some hospital clusters have also adopted special honorarium as a temporary measure to further increase its SOPC capacity.

(d) Piloting Cross-cluster Referrals

12. HA has enhanced cross-cluster collaboration by establishing a centrally coordinated mechanism to facilitate pairing-up patients in clusters of longer waiting time with clusters of shorter waiting time. Cross-cluster referrals has been piloted in the specialty of Ear, Nose and Throat (ENT) since August 2012. Suitable patients who are waiting to seek first consultation in ENT clinic of the Kowloon East Cluster have been offered the cross cluster referral option in the Kowloon Central Cluster. As at 31 March 2013, over 1 000 patients had benefited from the cross-cluster referrals arrangement. The waiting time for these patients was significantly reduced from over 100 weeks to around 12 weeks.

13. Similar cross-cluster referral arrangement has subsequently been put into place in the specialty of Gynaecology. Patients who have waited for a considerable period of time in the New Territories East Cluster will be referred to the Hong Kong East Cluster. Patients involved are mainly Gynaecology routine cases which are and referred for colposcopy and subfertility assessment.

(e) Public-Private Partnership (PPP)

14. The pilot public-private partnership (PPP) projects (e.g. the Cataract Surgeries Programme) have proved to be effective in alleviating the pressure of the public healthcare sector and providing more choices to patients. HA will explore the possibility of launching PPP projects to SOPC services with higher demand but of a non-acute nature, especially during the period of manpower shortage in the public sector.

(f) Enhancing Transparency

15. HA recognises the importance to enhance transparency in SOPC waiting time and to maintain public accountability and confidence in HA services. Since April 2013, HA has uploaded the SOPC waiting time for selected specialties on HA's website. The information will facilitate patients' understanding of the waiting time situation in HA and make informed decisions in treatment choice and plans. HA will continue to monitor the effect of making waiting time publicly available on patient flow and cross-cluster utilisation of SOPC services.

WAY FORWARD

16. As indicated in the 2013-14 Budget, improving waiting time is one of the priority areas in HA. On the workforce front, we expect that medical manpower shortage problem will improve when the number of medical graduates starts to go up to 320 in 2015 and to 420 in 2018. HA is also exploring with the Medical Council to increase the frequency of the Medical Licentiate Examination for foreign graduates.

17. On the infrastructure side, the Ambulatory Block at Tseung Kwan O Hospital has been completed and put into operation. The planning for the reprovision of Yaumatei Specialist Clinic commenced this year. These programs will help expand the physical capacity for SOPC service. There are other redevelopment projects underway, including Queen Mary Hospital, Kwong Wah Hospital and Kwai Chung Hospital in the years to come.

18. In 2013-14, HA will set up new case clinics and conduct additional doctor sessions to manage an additional of 13 000 specialist outpatient cases.

HA will remain vigilant to public demand and continue to identify pressure areas and allocate resources as appropriate for the provision of services in need so as to further improve the waiting time management for SOPC service.

OTHER ISSUE

19. On 16 April 2010, the Duty Roster Members met the Society for Community Organisation (SoCO) on the provision of medical services for children in poverty, and referred SoCO's recommendations for the deliberation by the Panel on Health Services. The Administration's responses to SoCO's recommendations are provided at **Annex 3**.

ADVICE SOUGHT

20. Members are invited to note the content of the paper.

Food and Health Bureau
Hospital Authority
June 2013

Annex 1

Median and 90th Percentile Waiting Time (Weeks) of New Case Booking of Routine Categories in Specialist Outpatient Clinics of Major Specialties in 2010-11 to 2012-13

Specialty	2010-11		2011-12		2012-13#	
	Median Waiting Time (weeks)	90th Percentile Waiting Time (weeks)	Median Waiting Time (weeks)	90th Percentile Waiting Time (weeks)	Median Waiting Time (weeks)	90th Percentile Waiting Time (weeks)
ENT	15	63	20	62	18	43
MED	25	52	31	57	34	68
GYN	16	91	18	97	17	70
OPH	29	67	25	87	32	73
ORT	32	84	43	103	52	107
PAE	12	31	13	31	15	35
PSY	9	50	12	55	16	70
SUR	25	110	27	110	30	110

Provisional figures

Specialty:
ENT – Ear, Nose & Throat
MED – Medicine
GYN – Gynaecology
OPH – Ophthalmology
ORT – Orthopaedics & Traumatology
PAE – Paediatrics and Adolescent Medicine
PSY – Psychiatry
SUR – Surgery

Annex 2

Specialist Outpatient Waiting Time (weeks) of New Cases by Major Specialties and Cluster in 2012-13 (with Breakdown by Triage Categories and Different Percentile)

Cluster	Specialty	Provisional figures																	
		Priority 1						Priority 2						Routine					
		Number of new cases	% of total new cases	Waiting Time (weeks)				Number of new cases	% of total new cases	Waiting Time (weeks)				Number of new cases	% of total new cases	Waiting Time (weeks)			
				25th	50th	75th	90th			25th	50th	75th	90th			25th	50th	75th	90th
				percentile						percentile						percentile			
HKE	ENT	1 385	17%	<1	<1	<1	<1	2 543	31%	1	3	7	8	4 226	52%	21	24	28	34
	MED	2 342	21%	<1	1	1	2	3 472	31%	2	4	7	7	5 536	49%	6	14	40	51
	GYN	738	14%	<1	<1	<1	1	876	16%	2	3	5	6	3 830	70%	11	16	22	25
	OPH	5 585	47%	<1	<1	<1	1	1 851	16%	5	7	8	8	4 418	37%	12	24	30	34
	ORT	1 880	20%	<1	1	1	1	2 208	24%	3	6	7	7	5 157	56%	13	32	50	51
	PAE	236	16%	<1	1	1	2	984	67%	3	5	6	7	243	17%	8	10	14	22
	PSY	581	17%	<1	1	1	2	658	19%	2	3	5	7	2 139	63%	4	8	19	28
	SUR	2 067	16%	<1	1	1	2	3 900	30%	5	7	7	8	6 982	54%	10	22	41	63
HKW	ENT	736	11%	<1	<1	1	1	2 213	34%	3	4	6	8	3 549	55%	4	16	31	35
	MED	1 509	13%	<1	<1	1	1	1 697	14%	3	3	5	7	8 825	73%	10	25	32	48
	GYN	1 174	16%	<1	<1	1	2	989	13%	3	5	6	7	4 416	60%	9	15	16	27
	OPH	3 783	36%	<1	<1	1	1	1 643	16%	3	4	6	7	5 024	48%	13	16	18	28
	ORT	821	8%	<1	<1	1	1	1 359	13%	2	3	5	6	8 277	79%	7	15	27	50
	PAE	341	14%	<1	<1	1	1	797	34%	2	5	6	8	1 218	52%	13	18	20	21
	PSY	280	7%	<1	1	1	2	448	11%	2	3	4	5	3 266	82%	3	8	20	60
	SUR	2 171	16%	<1	<1	1	2	2 400	17%	3	5	7	8	9 133	67%	5	20	48	81
KC	ENT	1 271	9%	<1	<1	<1	<1	1 223	8%	<1	<1	1	2	12 122	83%	3	9	12	16
	MED	1 736	15%	<1	1	1	1	1 425	12%	4	5	5	7	8 336	72%	13	25	32	67
	GYN	385	7%	<1	<1	1	1	1 862	35%	3	4	5	6	3 003	57%	8	11	24	37
	OPH	8 239	34%	<1	<1	<1	1	4 671	19%	1	2	4	6	10 409	43%	26	51	62	69
	ORT	731	9%	<1	<1	1	1	751	9%	2	3	5	7	6 806	82%	20	43	56	67
	PAE	425	20%	<1	<1	1	1	356	17%	3	5	6	7	1 332	63%	5	9	15	21
	PSY	493	18%	<1	<1	1	1	964	36%	2	4	6	7	1 246	46%	3	11	18	94
	SUR	2 224	13%	<1	1	1	1	2 793	16%	2	4	6	7	11 925	70%	16	19	38	73
KE	ENT	1 727	17%	<1	<1	1	1	2 457	24%	3	5	7	7	5 862	58%	23	40	44	151
	MED	1 833	10%	<1	1	1	1	4 088	22%	4	7	7	8	12 631	68%	12	40	48	68
	GYN	1 804	22%	<1	1	1	2	1 091	13%	3	6	7	7	5 257	64%	16	44	68	88
	OPH	5 157	29%	<1	<1	<1	1	2 160	12%	1	4	7	7	10 514	59%	11	22	70	72
	ORT	3 740	24%	<1	<1	1	1	3 171	20%	5	6	7	8	8 906	56%	32	107	121	140
	PAE	1 033	25%	<1	<1	<1	1	691	16%	3	6	7	7	2 471	59%	15	19	34	36
	PSY	553	8%	<1	1	1	2	1 899	26%	2	5	7	7	4 524	63%	9	28	59	78
	SUR	1 565	6%	<1	1	1	1	6 644	26%	6	7	7	8	17 010	67%	18	91	113	137

Cluster	Specialty	Priority 1						Priority 2						Routine					
		Number of new cases	% of total new cases	Waiting Time (weeks)				Number of new cases	% of total new cases	Waiting Time (weeks)				Number of new cases	% of total new cases	Waiting Time (weeks)			
				25th	50th	75th	90th			25th	50th	75th	90th			25th	50th	75th	90th
				percentile						percentile						Percentile			
KW	ENT	3 697	22%	<1	<1	1	1	4 360	26%	4	6	7	8	8 540	51%	14	21	31	33
	MED	2 823	10%	<1	<1	1	2	6 377	22%	4	5	7	7	19 954	67%	22	35	62	70
	GYN	1 082	8%	<1	<1	1	2	3 096	24%	3	5	6	7	8 756	67%	10	14	40	54
	OPH	6 022	32%	<1	<1	<1	<1	6 153	33%	2	4	5	6	6 595	35%	6	35	38	39
	ORT	4 269	22%	<1	<1	1	1	4 907	25%	3	5	6	7	10 618	54%	36	51	92	100
	PAE	2 556	34%	<1	<1	<1	1	948	13%	4	5	7	7	3 784	51%	5	9	13	15
	PSY	392	3%	<1	<1	1	1	943	6%	<1	3	6	8	13 462	91%	1	17	46	74
	SUR	4 763	13%	<1	1	1	2	9 121	25%	4	5	7	7	22 805	62%	14	32	74	116
NTE	ENT	4 129	28%	<1	<1	1	2	2 926	20%	3	3	5	7	7 749	52%	18	36	58	62
	MED	3 175	16%	<1	<1	1	1	2 465	12%	3	5	7	8	13 875	69%	24	52	64	71
	GYN	1 144	10%	<1	<1	1	2	864	8%	3	6	8	8	7 873	69%	25	49	77	125
	OPH	7 289	36%	<1	<1	1	1	3 014	15%	3	4	7	8	10 055	49%	17	73	124	155
	ORT	6 008	28%	<1	<1	<1	1	2 704	13%	4	5	7	8	12 876	60%	49	90	101	112
	PAE	630	15%	<1	<1	1	2	827	19%	3	5	7	8	2 843	66%	11	23	37	50
	PSY	1 518	17%	<1	1	1	2	2 019	23%	2	4	7	7	4 876	56%	7	24	49	81
	SUR	2 691	11%	<1	<1	1	2	3 638	15%	3	5	7	8	17 171	72%	15	31	67	100
NTW	ENT	2 783	22%	<1	<1	<1	1	1 509	12%	3	4	5	7	8 293	66%	13	20	29	33
	MED	1 140	12%	1	1	1	2	1 774	19%	6	6	7	7	6 544	69%	14	35	38	42
	GYN	1 016	15%	1	2	2	3	631	9%	3	5	7	7	5 080	76%	11	16	26	42
	OPH	5 938	29%	<1	<1	<1	<1	2 113	10%	1	3	5	7	12 125	60%	4	32	49	55
	ORT	1 286	10%	<1	1	1	1	1 246	10%	2	4	5	7	10 325	80%	25	63	71	75
	PAE	76	3%	<1	1	2	2	455	19%	4	5	7	8	1 843	78%	14	15	16	17
	PSY	509	8%	<1	1	1	1	1 790	27%	1	4	6	7	4 152	64%	4	13	22	27
	SUR	1 343	6%	<1	1	1	6	2 488	12%	3	5	7	15	17 254	82%	16	37	43	46
Overall HA	ENT	15 728	19%	<1	<1	1	1	17 231	21%	2	4	6	7	50 341	60%	10	18	31	43
	MED	14 558	13%	<1	<1	1	2	21 298	19%	3	5	7	7	75 701	67%	15	34	54	68
	GYN	7 343	13%	<1	1	1	2	9 409	16%	3	4	6	7	38 215	67%	11	17	44	70
	OPH	42 013	34%	<1	<1	<1	1	21 605	17%	2	4	6	7	59 140	48%	12	32	55	73
	ORT	18 735	19%	<1	<1	1	1	16 346	17%	3	5	7	7	62 965	64%	18	52	89	107
	PAE	5 297	22%	<1	<1	1	1	5 058	21%	3	5	7	7	13 734	57%	8	15	20	35
	PSY	4 326	9%	<1	1	1	2	8 721	18%	2	4	6	7	33 665	71%	4	16	40	70
	SUR	16 824	11%	<1	1	1	2	30 984	21%	4	6	7	8	102 280	68%	14	30	63	110

Abbreviations

Specialty:
ENT – Ear, Nose & Throat
MED – Medicine
GYN – Gynaecology
OPH – Ophthalmology
ORT – Orthopaedics & Traumatology
PAE – Paediatrics and Adolescent Medicine
PSY – Psychiatry
SUR – Surgery

Cluster:
HKE – Hong Kong East Cluster
HKW – Hong Kong West Cluster
KC – Kowloon Central Cluster
KE – Kowloon East Cluster
KW – Kowloon West Cluster
NTE – New Territories East Cluster
NTW – New Territories West Cluster

Annex 3

Provision of Medical Services for Children in Poverty

On 16 April 2010, the Duty Roster Members met the Society for Community Organisation (SoCO) on the provision of medical services for children in poverty, and subsequently referred SoCO's recommendations for the deliberation by the Panel on Health Services. The Administration's responses to the SoCO's recommendations are as follows:

(A) The provision of public healthcare services for children in poverty

Services by the Hospital Authority

2. The public healthcare is the cornerstone of our healthcare system, serving as the safety net for the whole community. The Hospital Authority (HA) is committed to providing publicly affordable and accessible healthcare services to address the wide ranging needs of the public, including children in poverty.

3. To enhance the clinical services for needy children, in 2013-14, HA will improve the long term management of ventilator assisted children through centralisation of the provision of care with multidisciplinary support and specialised facilities. HA will set up designated service at the Duchess of Kent Children's Hospital for ventilator assisted children, with three new beds to be opened, in the third quarter of 2013.

4. HA recognises healthcare manpower as one of the most important assets in the provision of quality services. In the past years, while the public healthcare sector is experiencing severe manpower shortage, HA has taken measures to enhance its manpower through various recruitment and staff retention initiatives. From 2011-12 to 2012-13, the number of doctors has increased from 5 165 to 5 260, and the number of nurses has increased from 20 901 to 21 816.

5. HA has introduced a number of measures to attract and retain healthcare professionals. These measures include:

(a) Enhancement of the special honorarium scheme, implementation of additional promotion mechanism and appointment of part-time doctors;

(b) Provision of short term employment of retired nursing staff and undergraduate nurses and improvement of working conditions and training opportunities for nurses; and

(c) Strengthening of phlebotomist services and clerical support.

6. The service of the HA's General Out-patient Clinics (GOPCs) is primarily targeted at low-income individuals, elders, and patients with chronic diseases. HA has been enhancing service capacity of GOPCs. For example, from 2010-11 to 2012-13, the number of attendances at the GOPCs had increased from 4.8 million to 5.6 million. In recent years, the attendances of persons aged under 18 takes up about 6% of the total attendance.

7. As to the specialist out-patient clinics (SOPC), it is the established practice for HA to arrange the date of medical appointment for new SOPC patients having regard to the urgency of their clinical conditions at the time of referral, taking into account various factors including the patients' clinical history, the presenting symptoms and the findings of physical examination and investigations under the triage system.

8. Referrals of new patients are triaged by respective specialty into priority 1 (urgent), priority 2 (semi-urgent) and routine categories. To ensure that cases with urgent medical conditions would receive prompt and timely attention, all referrals that have been classified as routine cases would be reviewed by a senior doctor of the relevant specialty within seven working days of the initial triage. In addition, if a patient's condition deteriorates before the appointment, the patient may contact the SOPC concerned and request for an earlier appointment. If the condition is acute, the patient could also seek immediate treatment at the Accident and Emergency departments. HA has been taking a series of measures to manage waiting time of SOPC and relevant information are presented in the main paper.

Services by the Department of Health

9. The School Service Medical Scheme (SSMS) was originally established in 1964 to provide financial aids to P1 to P3 students upon medical treatment from private medical practitioners. It was mainly for treatment purpose, and it lacked the elements of health promotion and disease prevention and it could not provide comprehensive care. The participation rate in SMSS was also low. In view of this, the 1990 report from the Primary Health Care Working Group recommended the establishment of Student Health Service (SHS) to replace the SSMS. With the main objectives on health promotion and disease prevention, the SHS was to provide health assessment and health education to P1 to S7 students individually on a regular basis. A continuous health record and more comprehensive and continuous healthcare services can hence be provided, helping monitor the health condition of the children. If the children had fallen ill, they could seek treatment from the GOPC of HA or the private sector. This recommendation was passed by Executive Council in 1991 and SHS was established under the Department of Health (DH) in the 1995-96 school year.

10. The Student Health Service Centres and Special Assessment Centres under SHS provide a comprehensive range of promotion and preventive services that cater for the health needs of the students at various stages of their development. In order to identify their health problems, students enrolled in the SHS are provided with a number of health screenings (growth, blood pressure, vision, hearing, psycho-social and spinal development etc) and physical examination. Furthermore, mop-up vaccinations, urine testing for obese student and health education are also provided. After the assessment, students will be provided with a personal health assessment report with advice. If necessary, the students would be arranged to receive individual counseling or referred to specialist, school counselor, school social worker or other social welfare service organization for further assessment.

11. We note the suggestion for SHS to include fitness and intellectual assessment and psycho-social assessment. At present, SHS already provides health assessment, physical examination and health counseling and also psycho-social heath assessment. Students in P4, P6, S2, S4 and S6 and parents of P2, P4 P6 students would complete a health assessment questionnaire when students attend their health screening. The aim is to make a preliminary assessment and identify those children and adolescents that could have emotional and behavioural problems for further assessment by medical personnel. If necessary, the students would be arranged to consult clinical psychologist or given referral as appropriate. Those who have learning

difficulty or studying problems would be followed up by the school or Education Bureau.

12. The Government's policy on dental care seeks to raise public awareness of oral health and facilitate the development of proper oral health habits through promotion and education, thereby improving oral health and preventing dental diseases. DH has been allocating resources primarily to promotion and preventive efforts. The School Dental Care Service (SDCS) encourages primary six students to continue to receive regular dental check-up from private dentists for oral health care maintenance after the SDCS ends. The Oral Health Education Unit under DH has launched various educational and promotional programmes specifically for different age groups having regard to their dental care needs including kindergarten and secondary school students. The "Brighter Smiles for the New Generation" Programme is targeted at children aged under age 6 studying in the local kindergartens and nurseries to help them establish good toothbrushing and smart diet habits for the prevention of dental diseases. There is a "Teens Teeth" programme to help secondary school students pay constant attention to oral health. There is also an annual "Love Teeth Campaign" in promotion of oral health to kindergarten and secondary school students. The Government will continue its efforts in promotion and education to improve oral health of the public.

(B) Medical Fee Waiving Mechanism

13. It has all along been the Government's policy objective that no one will be denied adequate medical care due to lack of means. Recipients of Comprehensive Social Security Assistance (CSSA) will be waived from payment of their public health care expenses. To assist the vulnerable groups in the community, including children in poverty who are not CSSA recipients, the Government has put in place a medical fee waiver mechanism to provide effective protection from undue financial burden to them. Patients who meet the specific financial criteria are eligible for a medical fee waiver.

14. At present, medical social workers and social workers have the discretion to decide the exact validity period of a medical fee waiver based on a patient's actual needs and conditions, with the longest period being twelve months. For the convenience of patients, the medical social workers and social workers may in advance grant medical fee waiver to a chronically ill patient

who frequently needs SOPC service, with a defined validity period to suit the patient needs.

15. To make the system more user-friendly, the waiver issued by medical social workers and social workers is not only applicable to the institution the patient is admitted, attends or obtains the waiver, but is also applicable to other public institutions that provide the same service, including in-patient service, out-patient services and community services, etc.

16. Hong Kong's healthcare system is provided primarily for Hong Kong residents. Our public healthcare services are heavily subsidised by the Government. It is necessary for the Administration to ensure that our public healthcare services can meet public demand and at the same time can sustain in the long-term within the limited financial resources. Therefore, we need to draw up eligibility criteria for receiving the heavily subsidised public healthcare services and accord priority to taking care of the needs of Hong Kong residents. Against this background, the provision of non-emergency services to Non-Eligible Persons (NEP) is subject to the availability of HA's capacity to provide such services, without adversely affecting the service to Eligible Persons (i.e. Hong Kong residents). And NEP, irrespective of age, is required to pay the fees and charges as stipulated in the relevant Gazette.

(C) Drug Formulary

17. HA implemented the Drug Formulary in July 2005 with a view to ensuring equitable access by patients to cost effective drugs of proven efficacy and safety. There are currently around 1 300 drugs in the Drug Formulary for treatment of various diseases. The vast majority of drugs prescribed to patients by HA doctors are provided at standard fees and charges in public hospitals and clinics. HA has an established mechanism for appraisal of new drugs and review of the drug list in its Drug Formulary. The review process follows an evidence-based approach, having regard to the principles of efficacy, safety and cost-effectiveness of drugs and taking into account various factors, including views of professionals and patient groups.

18. HA maintains close communications with patient groups on the development of Drug Formulary through established channels, including annual consultation meetings on the Drug Formulary and regular meetings between the

HA Chief Executive and patient representatives on various areas of patient services. HA will continue to review the Drug Formulary and enlist patients' engagement in the development of public healthcare services under the established mechanisms.

19. In recent years, the Government has provided additional resources to HA in order to meet the growth in drug expenses. HA's drug consumption expenditure has increased by more than 50% in the past five years, from $2.4 billion in 2008-09 to $3.75 billion in 2012-13. The additional funding has enabled HA to expand the coverage and widen the clinical applications of drugs in the Drug Formulary, including the treatment for rare metabolic diseases, thalassaemia, attention deficit hyperactivity disorder and diabetes mellitus for paediatric patients.

Food and Health Bureau

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